

SERVICE	LIMITATIONS
5. Hospital-Based Intermediate Care Please refer to Attachment 4.19D for reimbursement	<p><u>Limitations on payment</u> - All hospital-based nursing units must meet requirements as follows:</p> <ol style="list-style-type: none">1. The nursing unit must be composed of former acute care hospital beds that have been converted to and certified for skilled nursing or intermediate care.2. The need for the beds must have been approved by the local health planning agency.3. The distinct part unit may not exceed 50% of the facility's total licensed or approved bed complement for acute hospital care. A facility will, however, be granted an exception to the 50% bed limit if it submits written documentation to the Office of Medical Assistance Programs, Bureau of Long Term Care Programs substantiating that all of the following criteria have been met:<ol style="list-style-type: none">(i) beds operated in excess of the 50% bed limit have been approved by the Department of Health, Division of Need Review;(ii) the unit is located in an area underserved or lacking long term care beds under an approved local health plan;(iii) more than 50% of the unit's licensed long term care beds are occupied by medical assistance patients.4. A skilled nursing facility payment is made only for those beds which have been certified for skilled nursing care.
a. Heavy Care/Intermediate Services	<p><u>Limitations on payment</u> -</p> <ol style="list-style-type: none">1. Payment may be made to a nursing facility for heavy care/intermediate services when a recipient's level of care is heavy care/intermediate, only if the recipient is located in a dually certified skilled bed.2. The nursing facility shall be reimbursed for heavy care/intermediate services at the higher of the facility's applicable rates for skilled or intermediate care, as limited by the ceilings.
. Nurse Midwife Services	<p><u>Limitations on payment</u> - The following limits apply to payment for compensable services:</p> <ol style="list-style-type: none">1. Maximum of 12 visits per recipient per 365 day period.2. Payment for the delivery includes inpatient antepartum care and the postpartum care in the hospital and outpatient visits during the number of postpartum days specified for a delivery in the Medical Assistance Program Fee Schedule.

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SERVICE	LIMITATIONS
18. Hospice Services	<p><u>Limitations on payment</u> - The following limits apply to payment for compensable hospice services:</p> <ol style="list-style-type: none">1. Payment for inpatient respite care is limited to no more than 5 days in a 60 day certification period. Payment for inpatient respite care days in excess of the limit will be made at the routine home care rate.2. Payment is not made for general inpatient care if the Department determines that a lesser level of care was actually provided.3. The total payment to the hospice for inpatient care (general or respite) is subject to a limitation that the annual total of inpatient care days for medical assistance recipients not exceed 20 percent of the total days for which these patients had elected hospice care. The method used to calculate this limit for medical assistance pruposes is consistent with the Medicare regulations at 42 CFR § 418.302(f)(5) with one exception. Recipients with a confirmed diagnosis of acquired immune deficiency syndrome (AIDS) will not be counted when making this calculation.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Pennsylvania

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

9. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to Attachment 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

 X Provided: X With limitations*

 Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2) of the Act.

 Provided: With limitations*

 X Not provided.

10. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

 X Provided: + Additional coverage++

b. Services for any other medical conditions that may complicate pregnancy.

 X Provided: + Additional coverage++ Not provided.

11. Certified pediatric or family nurse practitioners' services.

 X Provided: No limitations X With limitations*

 Not provided.

+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

Description provided on attachment

SERVICE	LIMITATIONS
20. <u>Targeted Case Management Services</u>	See Enclosure
21. <u>Any other medical care and any other type of remedial care</u>	
21.a. Transportation	<u>Limitations on payment</u> - The following limits apply to payment for compensable ambulance transportation: 1. Transportation must be made to providers who are generally available and used by other members of the community. 2. Transportation must be made to or from services which are covered under the Medical Assistance Program. A partial list of noncovered services is contained in the Provider Handbook. 3. If more than one person is transported during the same trip, either to the same destination or a different destination, payment is made for transportation of the patient whose destination is the greatest distance. No additional payment is allowed for the additional person(s).
21.d. Skilled Nursing Facility Services for Patients Under 21 Years of Age Please refer to Attachment 4.19D for reimbursement	<u>Limitation on payment</u> - Limited to approved facilities. All hospital-based nursing units must meet requirements as follows: 1. The nursing unit must be composed of former acute care hospital beds that have been converted to and certified for skilled nursing or intermediate care. 2. The need for the beds must have been approved by the local health planning agency.

SERVICE	LIMITATIONS
21.d. Skilled Nursing Facility Services for Patients Under 21 Years of Age Please refer to Attachment 4.19D for reimbursement (Continued)	3. The distinct part unit may not exceed 50% of the facility's total licensed or approved bed complement for acute hospital care. A facility will, however, be granted an exception to the 50% bed limit if it submits written documentation to the Office of Medical Assistance, Bureau of Reimbursement Methods substantiating that all of the following criteria have been met: (i) beds operated in excess of the 50% limit have been approved by the Department of Health, Division of Need Review; (ii) the unit is located in an area underserved or lacking long term care beds under an approved local health plan; (iii) more than 50% of the unit's licensed long term care beds are occupied by Medical Assistance patients.
21.e. Emergency Hospital Services	<u>Limitations on payment</u> - The following limits apply to payment for compensable services: Described in item 2.a.(2).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: Commonwealth of Pennsylvania

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SERVICE MANAGEMENT AMENDMENT

STATE PLAN UNDER TITLE XIX OF THE
SOCIAL SECURITY ACT

Targeted Service Management
for Persons with Mental Retardation
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STATE: COMMONWEALTH OF PENNSYLVANIA
ENCLOSURE A TO ATTACHMENT 3.1A AND 3.1B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: PENNSYLVANIA

SERVICE MANAGEMENT

1. LOCATING SERVICES

Locating services consists of assistance to the recipient and his or her family in linking, arranging for, and obtaining services specified in an individual service plan. Activities shall include assessment of the individual's strengths and needs for the purpose of developing the plan, arranging for the plan to be developed, services referral, and problem resolution to ensure that persons gain access to needed services and entitlements.

2. COORDINATING SERVICES

Coordinating services consists of ongoing management of the service plan in cooperation with the recipient, his or her family, and providers of service. Activities include periodic review with the recipient of the individualized service plan, coordination of service planning with providers of service, contact with family, friends and other community members to coordinate the recipient's natural support network, and problem resolution related to coordination activities.

3. MONITORING SERVICES

Monitoring services consists of a process to assure that recipients receive the appropriate quality, type and level of services needed. Activities include monitoring of service plan implementation through interdisciplinary meetings and visits to providers of service; assessments of recipient progress and family satisfaction with services, arranging for modifications in service delivery; and advocacy to insure continuity of service, system flexibility and integration, proper utilization of facilities and resources, accessibility, and recipient's rights.

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SERVICE MANAGEMENT AMENDMENT

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SOCIAL SECURITY ACT

Targeted Service Management
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STATE: COMMONWEALTH OF PENNSYLVANIA
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: PENNSYLVANIA

SERVICE MANAGEMENT

E. QUALIFICATION OF PROVIDERS

The provider shall be an organizational unit consisting of multiple professional disciplines capable of locating, coordinating and monitoring necessary and appropriate services for persons with mental retardation.

Services shall be provided pursuant to OBRA of 1987, (P.L. 100-203, Section 4118 [i]) which permits designation of providers who are best able to ensure that eligible persons receive needed services and who meet and maintain the provider qualifications in the plan.

Each provider shall have the capability to:

1. Maintain a continuing relationship between the person with mental retardation, the family, and the facility or provider responsible for services.
2. Constitute a fixed point of referral and information for persons with mental retardation and their families.
3. Initiate, develop, and maintain a pattern of interaction between the diagnostic and evaluation teams and others concerned with services to the person with mental retardation and his/her family. This pattern must emphasize participation in the life-management planning process of the person with mental retardation and his/her family, physician, local public health nurse, teacher, representatives of human service resources, vocational services representatives, other providers of service, and advocates, whenever possible.

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SERVICE MANAGEMENT

4. Foster cooperation through the use of a multidisciplinary approach.
5. Ensure cooperation with other services involved in the diagnosis, evaluation and planning for the person.
6. Provide services which:
 - (i) evaluate the person's mental retardation and associated disabilities.
 - (ii) define the strengths, skills, abilities, and needs of the person.
 - (iii) assess the needs of the person and his/her family.
 - (iv) develop a practical plan for persons with mental retardation and their families.
 - (v) reassess the progress of the person at regular intervals to determine continuing need for services and for changes in the management plan.

The provider shall ensure that services are rendered by a qualified service manager.

Service managers shall meet current State Civil Service qualifications for caseworker, caseworker supervisor, or equivalent qualifications approved by the Department. Current standards for these positions are attached.

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SERVICE MANAGEMENT AMENDMENT

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STATE: COMMONWEALTH OF PENNSYLVANIA
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: PENNSYLVANIA

SERVICE MANAGEMENT

F. ASSURANCES

The State assures that the provision of service management will not restrict an individual's free choice of providers in violation of 1902(a)(23) of the Act.

1. Eligible recipients or an authorized representative will have free choice of the providers of service management.
2. Eligible recipients or an authorized representative will have free choice of the providers of other medical care under the plan.

The State assures that payment for service management under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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